HB2814

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

HB2814

by Rep. Camille Y. Lilly

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30.1
305 ILCS 5/5-30.11 new

Amends the Medical Assistance Article of the Illinois Public Aid Code. Requires the Department of Healthcare and Family Services to require managed care organizations (MCOs) to ensure: (1) that any provider under contract with an MCO on the date of service shall be paid for any medically necessary service rendered to any of the MCO's enrollees, regardless of inclusion on the MCO's published and publicly available roster of available providers; (2) that all contracted providers are listed on an updated roster within 7 days of entering into a contract with the MCO; and (3) that the roster under item (2) is readily accessible by all medical assistance enrollees for purposes of selecting an approved healthcare provider. Requires the Department to require MCOs to expedite payments to providers based on specified criteria (rather than providing that the Department may establish a process for MCOs to expedite payments to providers based on criteria established by the Department). Contains provisions concerning discharge notifications and facility placements and other matters. Effective immediately.

LRB101 09321 KTG 54416 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

1 AN ACT concerning public aid.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 5. The Illinois Public Aid Code is amended by
5 changing Section 5-30.1 and by adding Section 5-30.11 as
6 follows:

7 (305 ILCS 5/5-30.1)
8 Sec. 5-30.1. Managed care protections.
9 (a) As used in this Section:
10 "Managed care organization" or "MCO" means any entity which
11 contracts with the Department to provide services where payment
12 for medical services is made on a capitated basis.
13 "Emergency services" include:
14 (1) emergency services, as defined by Section 10 of the
15 Managed Care Reform and Patient Rights Act;
16 (2) emergency medical screening examinations, as
17 defined by Section 10 of the Managed Care Reform and
18 Patient Rights Act;
19 (3) post-stabilization medical services, as defined by
20 Section 10 of the Managed Care Reform and Patient Rights
21 Act; and
22 (4) emergency medical conditions, as defined by
23 Section 10 of the Managed Care Reform and Patient Rights

1 Act.
2 (b) As provided by Section 5-16.12, managed care
3 organizations are subject to the provisions of the Managed Care
4 Reform and Patient Rights Act.
5 (c) An MCO shall pay any provider of emergency services
6 that does not have in effect a contract with the contracted
7 Medicaid MCO. The default rate of reimbursement shall be the
8 rate paid under Illinois Medicaid fee-for-service program
9 methodology, including all policy adjusters, including but not
10 limited to Medicaid High Volume Adjustments, Medicaid
11 Percentage Adjustments, Outpatient High Volume Adjustments,
12 and all outlier add-on adjustments to the extent such
13 adjustments are incorporated in the development of the
14 applicable MCO capitated rates.
15 (d) An MCO shall pay for all post-stabilization services as
16 a covered service in any of the following situations:
17 (1) the MCO authorized such services;
18 (2) such services were administered to maintain the
19 enrollee's stabilized condition within one hour after a
20 request to the MCO for authorization of further
21 post-stabilization services;
22 (3) the MCO did not respond to a request to authorize
23 such services within one hour;
24 (4) the MCO could not be contacted; or
25 (5) the MCO and the treating provider, if the treating
26 provider is a non-affiliated provider, could not reach an

1 agreement concerning the enrollee's care and an affiliated
2 provider was unavailable for a consultation, in which case
3 the MCO must pay for such services rendered by the treating
4 non-affiliated provider until an affiliated provider was
5 reached and either concurred with the treating
6 non-affiliated provider's plan of care or assumed
7 responsibility for the enrollee's care. Such payment shall
8 be made at the default rate of reimbursement paid under
9 Illinois Medicaid fee-for-service program methodology,
10 including all policy adjusters, including but not limited
11 to Medicaid High Volume Adjustments, Medicaid Percentage
12 Adjustments, Outpatient High Volume Adjustments and all
13 outlier add-on adjustments to the extent that such
14 adjustments are incorporated in the development of the
15 applicable MCO capitated rates.
16 (e) The following requirements apply to MCOs in determining
17 payment for all emergency services:
18 (1) MCOs shall not impose any requirements for prior
19 approval of emergency services.
20 (2) The MCO shall cover emergency services provided to
21 enrollees who are temporarily away from their residence and
22 outside the contracting area to the extent that the
23 enrollees would be entitled to the emergency services if
24 they still were within the contracting area.
25 (3) The MCO shall have no obligation to cover medical
26 services provided on an emergency basis that are not

1 covered services under the contract.
2 (4) The MCO shall not condition coverage for emergency
3 services on the treating provider notifying the MCO of the
4 enrollee's screening and treatment within 10 days after
5 presentation for emergency services.
6 (5) The determination of the attending emergency
7 physician, or the provider actually treating the enrollee,
8 of whether an enrollee is sufficiently stabilized for
9 discharge or transfer to another facility, shall be binding
10 on the MCO. The MCO shall cover emergency services for all
11 enrollees whether the emergency services are provided by an
12 affiliated or non-affiliated provider.
13 (6) The MCO's financial responsibility for
14 post-stabilization care services it has not pre-approved
15 ends when:
16 (A) a plan physician with privileges at the
17 treating hospital assumes responsibility for the
18 enrollee's care;
19 (B) a plan physician assumes responsibility for
20 the enrollee's care through transfer;
21 (C) a contracting entity representative and the
22 treating physician reach an agreement concerning the
23 enrollee's care; or
24 (D) the enrollee is discharged.
25 (f) Network adequacy and transparency.
26 (1) The Department shall:

1 (A) ensure that an adequate provider network is in
2 place, taking into consideration health professional
3 shortage areas and medically underserved areas;
4 (B) publicly release an explanation of its process
5 for analyzing network adequacy;
6 (C) periodically ensure that an MCO continues to
7 have an adequate network in place; and
8 (D) require MCOs, including Medicaid Managed Care
9 Entities as defined in Section 5-30.2, to meet provider
10 directory requirements under Section 5-30.3; and ~~.~~
11 (E) require MCOs to: (i) ensure that any provider
12 under contract with an MCO on the date of service is
13 paid for any medically necessary service rendered to
14 any of the MCO's enrollees, regardless of inclusion on
15 the MCO's published and publicly available roster of
16 available providers; and (ii) ensure that all
17 contracted providers are listed on an updated roster
18 within 7 days of entering into a contract with the MCO
19 and that such roster is readily accessible to all
20 medical assistance enrollees for purposes of selecting
21 an approved healthcare provider.
22 (2) Each MCO shall confirm its receipt of information
23 submitted specific to physician or dentist additions or
24 physician or dentist deletions from the MCO's provider
25 network within 3 days after receiving all required
26 information from contracted physicians or dentists, and

electronic physician and dental directories must be updated consistent with current rules as published by the Centers for Medicare and Medicaid Services or its successor agency.

(g) Timely payment of claims.

(1) The MCO shall pay a claim within 30 days of receiving a claim that contains all the essential information needed to adjudicate the claim.

(2) The MCO shall notify the billing party of its inability to adjudicate a claim within 30 days of receiving that claim.

(3) The MCO shall pay a penalty that is at least equal to the penalty imposed under the Illinois Insurance Code for any claims not timely paid.

(4) The Department shall require MCOs to expedite payments to providers based on criteria that include, but are not limited to: ~~may establish a process for MCOs to expedite payments to providers based on criteria established by the Department.~~

(A) At a minimum, each MCO shall ensure that providers identified on the Department's expedited provider list, determined in accordance with 89 Ill. Adm. Code 140.71(b), are paid by the MCO on a schedule at least as frequently as the providers are paid under the Department's fee-for-service expedited provider schedule.

1 (B) Compliance with the expedited provider
2 requirement may be satisfied by an MCO through the use
3 of a Periodic Interim Payment (PIP) program that has
4 been mutually agreed to and documented between the MCO
5 and the provider, if the PIP program ensures that any
6 expedited provider receives regular and periodic
7 payments based on prior period payment experience from
8 that MCO. Total payments under the PIP program may be
9 reconciled against future PIP payments on a schedule
10 mutually agreed to between the MCO and the provider.

11 (g-5) Recognizing that the rapid transformation of the
12 Illinois Medicaid program may have unintended operational
13 challenges for both payers and providers:

14 (1) in no instance shall a medically necessary covered
15 service rendered in good faith, based upon eligibility
16 information documented by the provider, be denied coverage
17 or diminished in payment amount if the eligibility or
18 coverage information available at the time the service was
19 rendered is later found to be inaccurate; and

20 (2) the Department shall, by December 31, 2016, adopt
21 rules establishing policies that shall be included in the
22 Medicaid managed care policy and procedures manual
23 addressing payment resolutions in situations in which a
24 provider renders services based upon information obtained
25 after verifying a patient's eligibility and coverage plan
26 through either the Department's current enrollment system

or a system operated by the coverage plan identified by the patient presenting for services:

(A) such medically necessary covered services shall be considered rendered in good faith;

(B) such policies and procedures shall be developed in consultation with industry representatives of the Medicaid managed care health plans and representatives of provider associations representing the majority of providers within the identified provider industry; and

(C) such rules shall be published for a review and comment period of no less than 30 days on the Department's website with final rules remaining available on the Department's website.

(3) The rules on payment resolutions shall include, but not be limited to:

(A) the extension of the timely filing period;

(B) retroactive prior authorizations; and

(C) guaranteed minimum payment rate of no less than the current, as of the date of service, fee-for-service rate, plus all applicable add-ons, when the resulting service relationship is out of network.

(4) The rules shall be applicable for both MCO coverage and fee-for-service coverage.

(g-6) MCO Performance Metrics Report.

(1) The Department shall publish, on at least a

1 quarterly basis, each MCO's operational performance,
2 including, but not limited to, the following categories of
3 metrics:
4 (A) claims payment, including timeliness and
5 accuracy;
6 (B) prior authorizations;
7 (C) grievance and appeals;
8 (D) utilization statistics;
9 (E) provider disputes;
10 (F) provider credentialing; and
11 (G) member and provider customer service.
12 (2) The Department shall ensure that the metrics report
13 is accessible to providers online by January 1, 2017.
14 (3) The metrics shall be developed in consultation with
15 industry representatives of the Medicaid managed care
16 health plans and representatives of associations
17 representing the majority of providers within the
18 identified industry.
19 (4) Metrics shall be defined and incorporated into the
20 applicable Managed Care Policy Manual issued by the
21 Department.
22 (g-7) MCO claims processing and performance analysis. In
23 order to monitor MCO payments to hospital providers, pursuant
24 to this amendatory Act of the 100th General Assembly, the
25 Department shall post an analysis of MCO claims processing and
26 payment performance on its website every 6 months. Such

analysis shall include a review and evaluation of a representative sample of hospital claims that are rejected and denied for clean and unclean claims and the top 5 reasons for such actions and timeliness of claims adjudication, which identifies the percentage of claims adjudicated within 30, 60, 90, and over 90 days, and the dollar amounts associated with those claims. The Department shall post the contracted claims report required by HealthChoice Illinois on its website every 3 months.

(g-8) Notwithstanding any other provision of law, if the Department or an MCO requires submission of a claim for payment in a non-electronic format, a provider shall always be afforded a period of no less than 90 business days, as a correction period, following any notification of rejection by either the Department or the MCO to correct errors or omissions in the original submission.

Under no circumstances, either by an MCO or under the State's fee-for-service system, shall a provider be denied payment for failure to comply with any timely claims submission requirements under this Code or under any existing contract, unless the non-electronic format claim submission occurs after the initial 180 days following the latest date of service on the claim, or after the 90 business days correction period following notification to the provider of rejection or denial of payment.

(h) The Department shall not expand mandatory MCO

enrollment into new counties beyond those counties already designated by the Department as of June 1, 2014 for the individuals whose eligibility for medical assistance is not the seniors or people with disabilities population until the Department provides an opportunity for accountable care entities and MCOs to participate in such newly designated counties.

(i) The requirements of this Section apply to contracts with accountable care entities and MCOs entered into, amended, or renewed after June 16, 2014 (the effective date of Public Act 98-651).

(j) The requirements of this Section added by this amendatory Act of the 101st General Assembly shall apply to services provided on or after the first day of the month that begins 60 days after the effective date of this amendatory Act of the 101st General Assembly.

(Source: P.A. 99-725, eff. 8-5-16; 99-751, eff. 8-5-16; 100-201, eff. 8-18-17; 100-580, eff. 3-12-18; 100-587, eff. 6-4-18.)

(305 ILCS 5/5-30.11 new)

Sec. 5-30.11. Discharge notification and facility placement of individuals; managed care. Whenever a hospital provides notice to a managed care organization (MCO) that an individual covered under the State's medical assistance program has received a discharge order from the attending

1 physician and is ready for discharge from an inpatient hospital
2 stay to another level of care, the MCO shall secure the
3 individual's placement in or transfer to another facility
4 within 24 hours of receiving the hospital's notification, or
5 shall pay the hospital a daily rate equal to the hospital's
6 daily rate associated with the stay ending, including all
7 applicable add-on adjustment payments.

8 Section 99. Effective date. This Act takes effect upon
9 becoming law.